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A BRIEF SUMMARY OF TITLE XIX OF THE SOCIAL SECURITY ACT

1990

NOTE:
This is a very simplistic summary of a very complex subject. Please use this only as a general guide and an interim overview of the Medicaid program. This summary includes changes in the laws which became effective April 1, 1990, and quotes from the June 15, 1990 collection of 1989 data submitted by the States.

A BRIEF SUMMARY OF THE MEDICAID PROGRAM

Program Overview

Title XIX of the Social Security Act provides for a program of medical assistance for certain individuals and families with low incomes. The program, known as Medicaid, became law in 1965 as a jointly funded cooperative venture between the Federal and State governments. Federal oversight responsibility for the Medicaid program lies with the Health Care Financing Administration (HCFA) in the Department of Health and Human Services (DHHS). Within broad national guidelines which the Federal government provides, each State: (1) determines its own eligibility requirements; (2) determines the amount, duration, and scope of services; (3) determines the rate of reimbursement for services; and (4) administers its own program. Thus, the Medicaid programs vary considerably from State to State, and over time.

The Federal Medical Assistance Percentage (FMAP) portion of Medicaid expenses, to be paid by the Federal government, is determined annually for each State by a formula that compares a State's average per-capita income level with the national average. In 1989, this percentage varied from the prescribed minimum of 50% to 79.8% (the weighted average was 56%), with the wealthier States receiving lower FMAP matching rates. The amount of total Federal outlays for Medicaid has no set limit (cap). Rather, the Federal government must match whatever the individual State decides to provide, within the law, for its eligible recipients.

In 1989, the national Medicaid program provided services to about 24 million eligible poor persons who were: in certain families with dependent children, pregnant, aged, disabled, or blind. The combined Federal and State total outlay for the Medicaid program for 1989 was $57.9 billion ($32.7 billion Federal and $25.2 billion State monies).

Medicaid Eligibility

States generally have broad discretion in determining, within Federal guidelines and with FMAP support, which groups their Medicaid programs will cover and their financial criteria for Medicaid eligibility. States are required, however, to provide Medicaid coverage for most recipients who receive Federally assisted income-maintenance assistance payments, as well as for related groups not receiving cash payments. These mandatory Medicaid eligibility groups include:

- recipients of Aid to Families with Dependent Children (AFDC), (and two-parent, unemployed families whose cash assistance the State has elected to limit), including a limited extension of benefits for those who lose AFDC due to earnings from work;

- Supplemental Security Income (SSI) recipients, (or aged, blind and disabled individuals in States that apply more restrictive eligibility requirements);

- pregnant women, and children to age 6 whose family income is below 133% of Federal poverty level (FPL);

- certain Medicare beneficiaries (described later);

- recipients of adoption assistance and foster care under Title IV-E of the Social Security Act; and

- certain other specifically-defined groups (protected coverage for limited periods for these special groups).

States also have the option to provide Medicaid coverage for other "categorically needy" groups. These optional groups share characteristics of the mandatory groups, but the eligibility criteria are somewhat more liberally defined. The broadest optional groups that States may cover (and receive FMAP funds for) under the Medicaid program include:

- infants up to age 1 and pregnant women not covered under the mandatory rules whose family income is at or below 185% of the Federal poverty level (the percentage to be set by each State);

- other children under age 8, plus aged, blind or disabled adults who have incomes above those requiring mandatory coverage, but below the Federal poverty level;

- children under age 21 who meet income and resources requirements for AFDC, but who otherwise are not eligible for AFDC;

- institutionalized individuals with income and resources below specified limits;

- persons receiving care under home and community-based waivers;

- recipients of State supplementary payments; and

- "medically needy" persons (described below).

The option to have a "medically needy" (MN) program allows States to provide Medicaid eligibility to certain additional individuals and families: those who meet the eligibility requirements, except that they have income and/or countable resources above what is allowed under the mandatory or optional categorically needy levels, but below the MN level for that State. Within this MN option, qualified persons may also "spend down" to Medicaid eligibility by incurring medical care expenses that reduce their excess finances to a level below that allowed by their State's plan.

If a State elects to have a medically needy program, it is required to provide coverage to certain children under age 18 and pregnant women. It may also choose to provide coverage to other medically needy persons: aged, blind, and/or disabled persons; caretaker relatives of children deprived of parental support and care; and certain other financially eligible children up

to age 21. During 1989, thirty-nine States provided Medicaid to at least some groups under a medically needy program.

Medicaid does not provide health care services for all poor persons. To be eligible for Medicaid, a person must belong to one of the groups designated above, as well as meet income and assets/resources tests. Even under the broadest provisions of the Federal statute (except for a few emergency services for certain persons) the Medicaid program does not provide health care services, even for very poor persons, unless they are: under age 21, pregnant, aged, blind, disabled, or in certain AFDC-type families.

Some States also have some additional "State-only" programs to provide medical assistance for specified poor persons who do not qualify for the Medicaid program. These programs also vary greatly among States. Matching Federal funds are not provided for these State-only programs.

Scope of Medicaid Services

Title XIX of the Social Security Act requires that, in order to receive Federal matching funds, certain basic services must be offered in any State Medicaid program:

- inpatient hospital services;
- outpatient hospital services;
- prenatal care;
- physician services;
- early and periodic screening, diagnosis, and treatment (EPSDT) services for children under age 21, including services beyond those normally in State plans for conditions identified in the screening examination;
- skilled-nursing facility (SNF) services for individuals aged 21 or older;
- home health care for persons eligible for skilled-nursing services;
- family planning services and supplies (at 90% FMAP for all States);
- rural health clinic services;
- laboratory and x-ray services;
- nurse-midwife services; and
- certain Federally-qualified ambulatory & health-center services.

States may also receive Federal matching funds if they elect to provide other optional services (currently 32 options). The most commonly covered optional services under the Medicaid program include:

- clinic services;
- intermediate-care facility (ICF) services for the aged and disabled;
- ICF services for the mentally retarded (ICFs/MR);
- optometrist services and eyeglasses;
- prescribed drugs;
- prosthetic devices; and
- dental services.

Amount and Duration of Medicaid Services

Within broad Federal guidelines, States determine the duration and amount of services offered under their Medicaid programs. They may limit, for example, the days of hospital care or the number of physician visits covered. With certain exceptions, a State's Medicaid plan must allow recipients freedom of choice among participating providers of health care. States may provide and pay for Medicaid services through various pre-payment arrangements, such as health maintenance organizations (HMOs).

In general, States are required to provide comparable services to all categorically needy eligible persons. Under two important exceptions, States provide additional services to limited groups: 1) States may request administrative "waivers" under which they offer an alternative health care package for persons who would otherwise be institutionalized under Medicaid. States are not limited in the scope of services they can provide under such waivers so long as they are cost effective (except that, other than as a part of respite care, they may not provide room and board for such "waivered" recipients). 2) Under the EPSDT program, services that are identified as needed by eligible children must be provided by Medicaid, even if those services are not included as part of that State's Medicaid plan.

Medicaid - Medicare Relationship

Some aged or disabled poor persons are covered under both the Medicaid and the Medicare (Title XVIII of the Social Security Act) programs. These recipients are known as "dual eligibles" or "dual beneficiaries". The Medicare program provides hospital insurance (HI - also known as "Part A") and supplementary medical insurance (SMI - also known as "Part B"). For those persons who are aged (65 or older) or disabled and who have insured status under Social Security, coverage for Part "A" is automatic. (Other persons aged 65 or over but not covered by Social Security may obtain Part "A" coverage by paying the monthly premium.)

Coverage for Part "B", however, requires payment of a monthly premium. State Medicaid programs pay the premiums, deductibles and coinsurance for some or all dual-eligible persons. Medicaid supplements Medicare, providing certain health care services for the dual-eligible recipients that are not provided under Medicare, such as hearing aids, eye glasses, and SNF services beyond the 100 day Medicare limit.

The 1988 Medicare Catastrophic Coverage Act (MCCA) significantly impacted the Medicare and Medicaid programs. The portion of MCCA which was not rescinded requires that State Medicaid programs begin (on a phased-in basis) to pay for the Medicare premiums, deductibles, and coinsurance for certain other aged or disabled "qualified Medicare beneficiaries" (QMBs): those with incomes at or below 90% (phased in to 100% by 1992) of the Federal poverty level and with resources at or below twice the standard allowed under SSI. This assures Medicare coverage for those eligible Medicare recipients who are not quite poor enough to qualify for Medicaid, but who would have difficulty paying the Medicare co-payments.

The QMBs with income and resources above Medicaid eligibility levels are not eligible for full Medicaid coverage because of the new law; they benefit because their Medicare cost-sharing expenses are covered by Medicaid. The MCCA law also accelerates eligibility for Medicaid for some nursing home patients by protecting more family income and assets for the institutionalized persons' spouses at home. In addition, the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) requires Medicaid buy-in of Part "A" Medicare coverage for disabled persons who lost Medicaid benefits because of their return to work.

Payment Rates for Medicaid Services

Medicaid operates as a vendor payment program. States pay the providers of medical services for care rendered to eligible individuals. Providers must accept the Medicaid reimbursement level as payment in full. Payment rates must be sufficient to enlist enough providers so that Medicaid care and services are available under the plan at least to the extent that such care and services are available to the general population in that geographic area. Also, States must augment payments to qualified hospitals that provide inpatient health care services to a disproportionate number of Medicaid recipients and/or other low-income persons.

States have broad discretion in determining the reimbursement methodology and resulting rates for services, subject to Federal upper limits, with two exceptions: (1) for institutional services, payments may not exceed Medicare reasonable-cost payment rates; and (2) for hospice care services, they must pay Medicare rates.

States may impose nominal deductibles, coinsurance or co-payments on some Medicaid recipients for certain services. Emergency services and family planning services must be exempt from such co-payments by recipients. Certain Medicaid recipients must be excluded from this cost sharing: pregnant women, children under age 18, hospital or nursing home patients who are expected to contribute most of their income to institutional care, and categorically needy HMO enrollees.

Medicaid Statistics and Trends

Medicaid was initially formulated as a medical care extension of Federally funded income maintenance programs for the poor. Over time, however, Medicaid has been diverging from a firm tie to eligibility for cash programs. Recent legislation assures Medicaid coverage to many low-income pregnant women, children and some Medicare beneficiaries who are not eligible for any cash assistance program, and who would not have been eligible for Medicaid under the earlier Medicaid rules.

The most pronounced Medicaid trend over the years has been the continued sharp increase in expenditures for nursing home care for the mentally retarded, aged and disabled recipients. In FY 1989: (1) for nursing

facilities for the mentally retarded (ICFs/MR) the average Medicaid payment (in addition to health services rendered outside the facility, such as hospital care, etc.) was about $45,000 per recipient, and (2) the average Medicaid payment to nursing facilities for care for others (mainly those aged 65 and over) was about $10,700 per recipient, while (3) Medicaid payments for total health care services for AFDC children averaged under $670 per child.

Medicaid data for recipients and expenditures are submitted annually by each State to HCFA headquarters on the "HCFA 2082" form. A draft compilation of the 2082 data for 1989, reported as the Annual Medicaid Statistical Data Base, shows: total (State and Federal) Medicaid payments to vendors for all Medicaid services was $54.5 billion, with services provided nationally to about 24 million Medicaid recipients. Details from this initial report include -

Numbers by categories of people and vendor payments for these people:

.	10,318,000	were dependent children under age 21	@ $ 6,891,900,000;
.	5,717,000	were adults in AFDC families	@ $ 6,896,500,000;
.	3,132,000	were aged 65 or older	@ $18,558,300,000;
.	3,496,000	were permanently & totally disabled	@ $20,476,100,000;
.	95,000	were blind	@ $ 409,416,000;
.	1,175,000	were other Title XIX recipients	@ $ 1,267,000,000.

Numbers by categories of services and vendor payments for these services:

.	1,600,000	received nursing facilities services	@ $22,180,597,000;
.	4,260,000	received inpatient hospital services	@ $14,847,815,000;
.	15,916,000	received prescription drug services	@ $ 3,688,781,000;
.	15,686,000	received physician services	@ $ 3,407,871,000;
.	11,344,000	received outpatient hospital services	@ $ 2,837,064,000;
.	609,000	received home health services	@ $ 2,572,335,000;
.	4,588,000	received other/unidentified services	@ $ 1,916,186,000;
.	2,391,000	received clinic services	@ $ 1,249,226,000;
.	7,759,000	received lab and x-ray services	@ $ 590,107,000;
.	4,214,000	received dental services	@ $ 497,855,000;
.	3,555,000	received other practitioner services	@ $ 316,679,000;
.	1,564,000	received family planning services	@ $ 227,247,000;
.	2,521,000	received EPSDT services	@ $ 146,335,000;
.	166,000	received rural health clinic care	@ $ 22,106,000.

Our Nation spent approximately $50 billion for all nursing facility care in 1989. Medicaid recipients using long term care services composed only seven percent (7%) of the Medicaid recipients, yet they consumed forty-one percent (41%) of the Medicaid expenditures. As our population continues to "age", and as medical advances keep more technologically-dependent persons alive and in need of long term care, Medicaid expenditures for long term care services are expected to increase significantly.

Total Federal outlays for the Medicaid program have increased from $2.5 billion in fiscal year (FY) 1970 to $32.7 billion in FY 1989. Under current law, the projected growth of Federal Medicaid expenditures between FY 1989 and FY 1995 is expected to average a compound rate of over 13% per year (or a doubling in about five and one-half years). Thus, if current trends continue and there are no significant changes to the Medicaid program, the

monies expected to be required as payments for the total Federal and State Medicaid program for 1995 are projected to be over $120 billion, and by the year 2000 could approach $200 billion.

Conclusion

Expenditures in the Medicaid program over the years have far exceeded the increase in numbers of persons or services provided. That is, the cost per Medicaid recipient has increased annually. This is due, primarily, to:

- the results of technological advances to keep more very low birth-weight babies and other critically ill or severely injured persons alive, but in need of continuing very expensive care;
- the increase in rates of reimbursement to the providers of health care services;
- the increase in the numbers of very old persons and their required health care and related services; and
- the accelerated rate of inflation for medical and health related services when compared to general inflation.

Federal and State decision-makers for the Medicaid programs continually seek improvements in the quality and extent of health care services. Yet, they must function within the constraints of various budgetary limitations as well as other economic, social, and political factors that affect State and national decisions. Thus, with frequent revisions in HCFA regulations, Federal laws, and individual State plans, the Medicaid program is continually changing. This was the Medicaid program as of September 1, 1990.

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